JRAAS
Special Issue in Medicine & Surgery
www.internationalmedicalpublishing.com

Case Report

Section: Obstetrics & Gynecology

From Silent Retention to Pelvic Sepsis: Vaginoscopic Removal of a Vaginal Foreign Body followed by Laparoscopic Drainage of Tubo Ovarian Abscess in a 13 Year Old

Pallavi Krishna[1*], Pushpawati Thakur[1], Sarita Agrawal[1], Sarita Rajbhar[1], Manish Kumar[2], Nitin Kumar Borkar[3] & Nisha Watti[1]

[1]Department of Obstetrics & Gynecology, All India Institute of Medical Sciences, Raipur, Chhattisgarh, India

[2]Department of Radio-diagnosis, All India Institute of Medical Sciences, Raipur, Chhattisgarh, India

[3]Department of Pediatric Surgery, All India Institute of Medical Sciences, Raipur, Chhattisgarh, India

HIGHLIGHTS

- Atypical symptoms delay diagnosis
- MRI detected a foreign body
- Vaginoscopy-aided removal
- Foreign bodies caused an abscess
- Multidisciplinary care essential

Key Words:
Vaginal foreign body
Adolescent lower abdominal pain
Paediatric gynaecology
Case report

ABSTRACT

Introduction: Vaginal foreign bodies are uncommon in adolescents and often present with nonspecific or absent genital symptoms, leading to delayed diagnosis. Common manifestations include vaginal discharge, bleeding, recurrent infection, or pelvic pain, although some patients may remain asymptomatic. Prolonged retention may result in chronic inflammation, adhesions, pelvic inflammatory disease, and tubo-ovarian abscess formation. Early imaging and vaginoscopic evaluation are essential for timely diagnosis and prevention of complications. **Aim & Objective:** To highlight an unusual presentation of a vaginal foreign body in an adolescent girl without genital symptoms and to emphasize the importance of imaging and multidisciplinary management in preventing complications. **Case Presentation:** A 13-year-old premenarchal girl presented with intermittent lower abdominal pain, fever, and vomiting for two weeks without vaginal complaints. Ultrasonography suggested bilateral adnexal masses with right hydrosalpinx and a possible vaginal foreign body. Contrast-enhanced MRI revealed bilateral tubo-ovarian abscesses with a suspected vaginal foreign body. Psychiatric and forensic evaluations were performed due to medicolegal concerns. Diagnostic vaginoscopy under general anaesthesia identified a cylindrical plastic lipstick cap measuring 3 × 2 cm lodged transversely in the upper vagina with adhesions and pus collection. **Result:** The foreign body was successfully removed under vaginoscopic guidance with minimal trauma, followed by laparoscopic drainage of bilateral tubo-ovarian abscesses. The patient recovered without complications following multidisciplinary management. **Conclusion:** Vaginal foreign bodies should be considered in adolescents presenting with unexplained abdominal or pelvic symptoms, even in the absence of genital complaints. Early imaging, prompt diagnosis, and multidisciplinary evaluation are essential to avoid delayed treatment and serious complications.

*** Corresponding Author:** Pallavi Krishna, e-mail: pallavikrishna32@gmail.com
Article History: Received 12 April 2026; Received in Revised form 15 May 2026; Accepted 22 May 2026
How To Cite: Pallavi Krishna, Pushpawati Thakur, Sarita Agrawal, Sarita Rajbhar, Manish Kumar, Nitin Kumar Borkar & Nisha Watti. From Silent Retention to Pelvic Sepsis: Vaginoscopic Removal of a Vaginal Foreign Body followed by Laparoscopic Drainage of Tubo Ovarian Abscess in a 13 Year Old. *JRAAS : Special Issue in Medicine & Surgery.* 2026;41(1):1-8. DOI: https://doi.org/10.71393/9t6dvv79

INTRODUCTION

Vaginal foreign bodies (VFBs) are an important but often under-recognised cause of gynaecological symptoms in children and adolescents. They are more commonly encountered in pre-pubertal girls, particularly those younger than 9 years of age, although cases in older adolescents have also been reported [1]. The clinical presentation is frequently nonspecific and may vary from complete absence of symptoms to complaints of persistent foul-smelling vaginal discharge, bleeding, recurrent vulvo-vaginitis, dysuria, pelvic pain, lower abdominal discomfort, urinary frequency, or urinary tract infections [2,3]. In many patients, particularly younger children, the history of insertion is often not volunteered because of embarrassment, fear, poor recollection, or lack of awareness. Insertion may occur accidentally, during self-exploration, or, less commonly, in the context of abuse. Therefore, clinicians must approach these cases with sensitivity and maintain awareness of potential safe guarding concerns [4].

The anatomy and physiology of the prepubertal vagina contribute significantly to the susceptibility to irritation and infection in the presence of a retained foreign body. In premenarchal girls, the vaginal mucosa is thin, fragile, and hypo-oestrogenic, with an alkaline pH and minimal protective lactobacillary flora [5]. These factors predispose the vaginal epithelium to inflammation, colonisation by pathogenic organisms, & mucosal injury when foreign material remains in situ for a prolonged duration. Chronic retention may result in persistent local irritation and ascending infection. The duration of retention may vary from a few days to several years, with some reports describing foreign bodies discovered only after the development of severe complications [6].

Diagnosis of vaginal foreign bodies remains challenging because classic genital symptoms may be absent in a substantial proportion of patients. Up to one-third of children with retained vaginal foreign bodies do not present with obvious vaginal complaints, contributing to delayed diagnosis and repeated unsuccessful treatment for presumed urinary tract infection, vulvovaginitis, pelvic inflammatory disease, or abdominal pathology [3]. Commonly retained objects include toilet paper, beads, pen caps, hair clips, safety pins, small toys, batteries, plastic bottle caps, and cosmetic accessories such as lipstick covers [2,7]. In adolescents, objects may occasionally be inserted intentionally during self-exploration, experimentation, or sexual activity, whereas in younger children accidental insertion is more common [4].

Prolonged retention of vaginal foreign bodies can lead to serious complications. Chronic inflammation may result in ulceration, fibrosis, adhesions, vaginal stenosis, recurrent urinary tract infections, pelvic inflammatory disease, vaginolith formation, and fistulae involving the bladder or rectum [6,8]. Cases of vesicovaginal fistula, rectovaginal fistula, and bladder calculus formation secondary to neglected foreign bodies have been described [8]. Button batteries represent a particularly dangerous type of vaginal foreign body because they can rapidly produce tissue necrosis through leakage of alkaline contents and electrical injury, leading to severe mucosal destruction within hours [9].

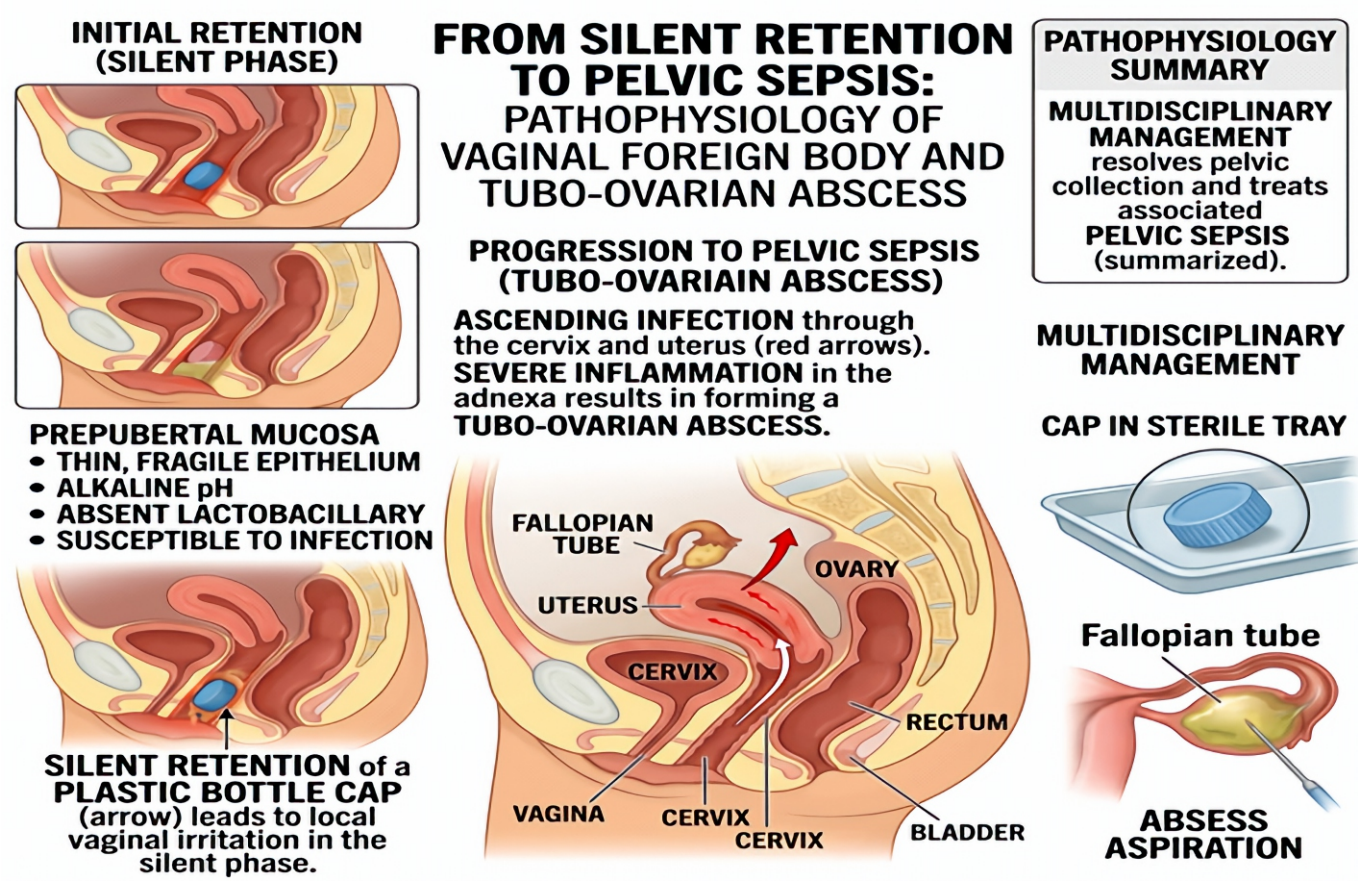

Figure 1: Progression of a retained vaginal foreign body causing ascending infection, tubo-ovarian abscess, and pelvic sepsis with its surgical management.

A thorough history and careful physical examination are essential in suspected cases of vaginal foreign body. However, genital examination may be difficult in anxious children or in adolescents who are not sexually active. In such situations, imaging may provide important diagnostic clues. Ultrasonography is generally used as the first-line investigation because it is non-invasive, inexpensive, and widely available. However, its sensitivity is limited, particularly for small, non-radiopaque, or deeply retained foreign bodies [10]. Plain radiographs may help identify radiopaque objects but are frequently normal in cases involving plastic, paper, or organic material. Magnetic reso-nance imaging (MRI) may be particularly valuable in complex or atypical presentations, when ultrasonography is inconclus-ive, when vaginal examination is difficult, or when associated pelvic pathology is suspected. MRI offers superior soft-tissue characterisation and can identify associated abscesses, adhesi-ons, pelvic inflammatory changes, and adjacent organ involve-ment [11].

Vaginoscopy remains the gold standard for both diagnosis and management of vaginal foreign bodies. It allows direct visualisation of the vaginal canal and cervix and permits safe removal of retained objects under direct vision. The procedure can be performed under sedation or general anaesthesia depending on the age, cooperation, and clinical status of the patient. Recent literature continues to support vaginoscopy as a minimally invasive, safe, and highly effective method with excellent diagnostic yield in paediatric and adolescent patients [7,12]. In addition to facilitating removal, vaginoscopy also permits evaluation for mucosal injury, adhesions, infection, and possible evidence of trauma or abuse.

Tubo-ovarian abscess (TOA) is a complication of pelvic inflammatory disease and is most commonly encountered in sexually active women of reproductive age. However, its occurrence in sexually inactive adolescents is rare and may result in diagnostic confusion. In such patients, unusual sources of ascending pelvic infection, including retained vaginal foreign bodies, urinary tract infections, appendicitis, inflammatory bowel disease, poor hygiene, or congenital genital tract anomalies, should be considered [13,14]. TOA may present with fever, abdominal pain, vomiting, adnexal masses, leukocytosis, and elevated inflammatory markers, but symptoms are often nonspecific. Delayed diagnosis may lead to sepsis, infertility, chronic pelvic pain, or the need for extensive surgical intervention [15]. **Figure 1** shows the progression of a retained vaginal foreign body leading to ascending infection, tubo-ovarian abscess, and pelvic sepsis.

The present case is unusual because the patient had no vaginal complaints and initially presented only with lower abdominal pain, fever, and vomiting. The vaginal foreign body was suspected by ultrasonography and identified during an MRI performed for evaluation of suspected tuboovarian pathology. This case underlines the importance of maintaining a high index of suspicion for vaginal foreign body in any young girl with unexplained pelvic symptoms, persistent infection, or atypical imaging findings, even in the absence of vaginal discharge or bleeding. It also highlights the importance of multidisciplinary management involving radiology, paediatric gynaecology, psychiatry, and forensic services, particularly in minors, where medicolegal concerns must be addressed carefully.

CASE PRESENTATION

A 13-year-old pre-menarchal adolescent girl presented to the Gynaecology Outpatient Department of All India Institute of Medical Sciences (AIIMS), Raipur, accompanied by her parents. She reported a two-week history of intermittent lower abdominal pain, associated with non-bilious vomiting and on-and-off low-grade fever. She denied any vaginal symptoms, including discharge, bleeding, itching, or pain during mictur-ition. There was no history of trauma, sexual abuse, or prior gynecological complaints. She also denied any history of self-genital manipulations.

On general examination, the patient appeared thin built with a body mass index (BMI) of 17.1 kg/m², and had brittle nails, suggestive of possible nutritional deficiency. Secondary sexual characteristics corresponded to her age. Vital signs were within normal limits. Her temperature ranged between 99-100 degree Fahrenheit. Abdominal examination revealed mild tenderness in the lower abdomen, without palpable masses or signs of peritoneal irritation. External genital examination revealed normal vulvar anatomy, and there was no evidence of vaginal discharge, erythema, or trauma.

Laboratory investigations revealed moderate microcytic hypochromic anaemia, with haemoglobin 8.6 g/dL. Urine culture grew Escherichia coli, sensitive to Nitrofurantoin. Despite appropriate antibiotic therapy and symptomatic management with antiemetics and analgesics, intermittent fever, vomiting, and lower abdominal tenderness persisted.

Initial pelvic ultrasonography suggested a bilateral adnexal mass with right-sided hydrosalpinx and suspicion of a foreign body in the vagina, raising concern for possible pelvic inflammatory disease. To further evaluate pelvic anatomy and rule out complications, a contrast-enhanced MRI (CE-MRI) was performed. MRI revealed bilateral tubo-ovarian abscesses and a well-defined mixed signal intensity area of around 1.2x1.2cm seen in vaginal cavity just below the cervix -likely foreign body.

Given the age of the patient and MRI suspicion of a vaginal foreign body in a minor, psychiatry and forensic consultations were obtained. Sensitive and non-leading counselling was performed with both the patient and her parents. Even on repeated questionnaires, no history regarding insertion or exposure to the foreign body could be elicited.

In view of the MRI diagnosis of a foreign body in the vagina, vaginoscopy under general anesthesia was performed using a 4mm hysteroscope with saline as distension medium. Insertion of the hysteroscope was a bit difficult due to adhesions in the vagina, likely due to chronic irritation or inflammatory response. Gentle adhesiolysis was performed. A cylindrical foreign body measuring approximately 3 × 2 cm, placed transversely in the upper vaginal canal, was visualised. Around 4 ml of pus collection was noted and was collected & was sent for culture & sensitiv-

ity. The object was carefully removed without causing trauma to the vaginal mucosa. She also underwent laparoscopic drainage of bilateral tubo-ovarian abscess and was given culture specific antibiotics following which her symptoms were resolved completely and hence was discharged with advice to follow up.

RESULT

Diagnostic vaginoscopy under general anaesthesia confirmed the presence of a cylindrical plastic foreign body measuring approximately 3 × 2 cm lodged transversely in the upper vaginal canal. The foreign body was associated with vaginal adhesions and approximately 4 ml of pus collection, suggestive of chronic inflammatory reaction secondary to prolonged retention. Gentle adhesiolysis was performed to facilitate visualization and safe removal of the object under hysteroscopic guidance, without causing trauma to the vaginal mucosa. Pus collected from the vaginal cavity was sent for culture and sensitivity testing.

Intraoperative findings correlated with radiological suspicion of pelvic inflammatory pathology. Laparoscopic evaluation further confirmed bilateral tubo-ovarian abscesses, which were successfully drained. Postoperatively, the patient was managed with culture-specific antibiotics along with supportive care. Following removal of the foreign body and drainage of the abscesses, there was complete resolution of intermittent fever, vomiting, lower abdominal pain, and abdominal tenderness. No post-operative complications were observed, and the patient demonstrated satisfactory clinical recovery. She was discharged in stable condition with advice for follow-up and continued multidisciplinary monitoring. **Figure 2** shows transabdominal ultrasonography findings suggestive of bilateral tubo-ovarian masses.This case demonstrated that vaginal foreign bodies in adolescents may remain clinically silent and present only with secondary pelvic complications. Early imaging, timely vaginoscopic evaluation, and multidisciplinary intervention played a crucial role in establishing the diagnosis, preventing further morbidity, and ensuring complete recovery. **Figure 3** shows a sagittal T2-weighted MRI revealing bilateral tubo-ovarian abscesses and a vaginal foreign body. Axial T2-weighted pelvic MRI showing a vaginal foreign body **(Figure 4). Figures 4** and **5** demonstrate axial T2-weighted pelvic MRI and diagnostic vaginoscopy findings revealing the vaginal foreign body. **Figure 6** shows vaginoscopic visualization of the retained foreign body within the vaginal cavity, while **Figure 7** depicts the cylindrical lipstick cap measuring 3 × 2 cm extracted from the vaginal cavity.

Figure 2: Transabdominal ultrasound demonstrating bilateral tubo-ovarian mass

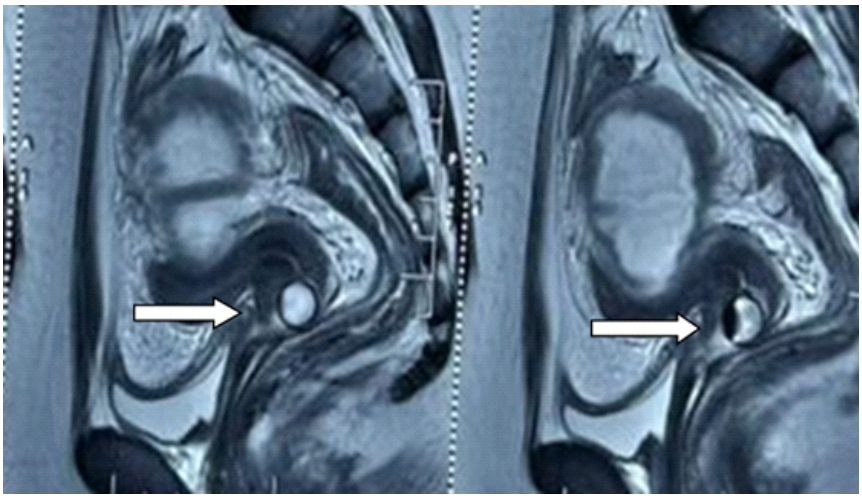

Figure 3: Sagittal T2-weighted MR images illustrating bilateral tubo-ovarian abscess and a foreign body in the vaginal cavity

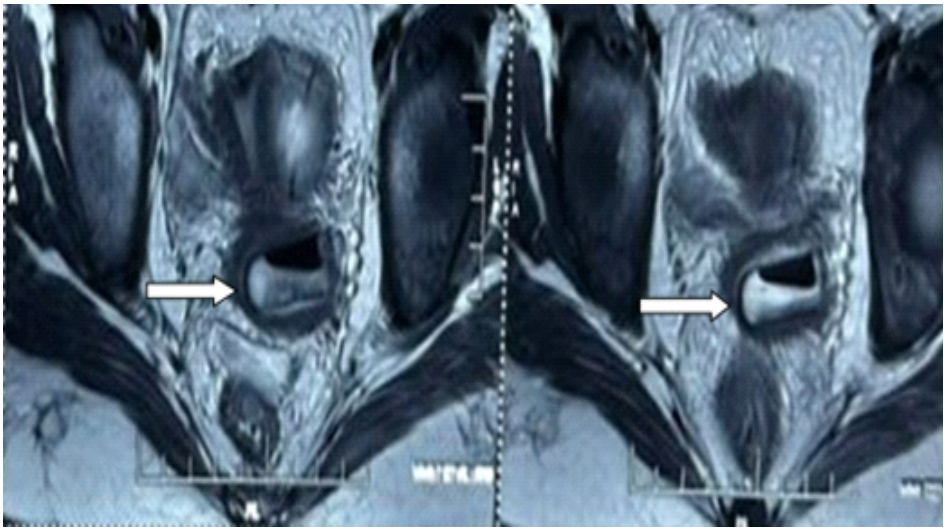

Figure 4: Pelvic MRI-Axial T2-weighted images showing foreign body

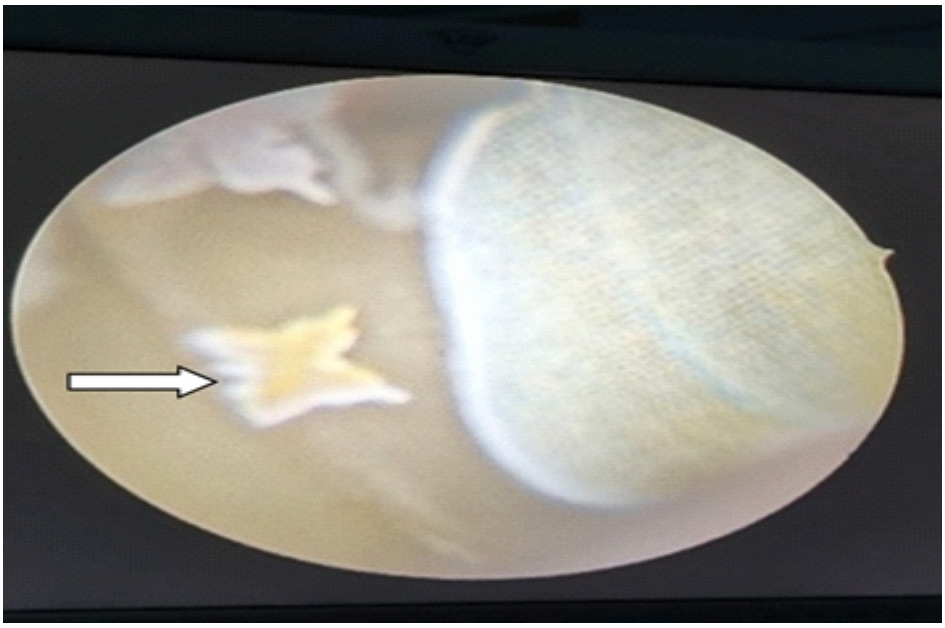

Figure 5: Diagnostic vaginoscopy showing foreign body

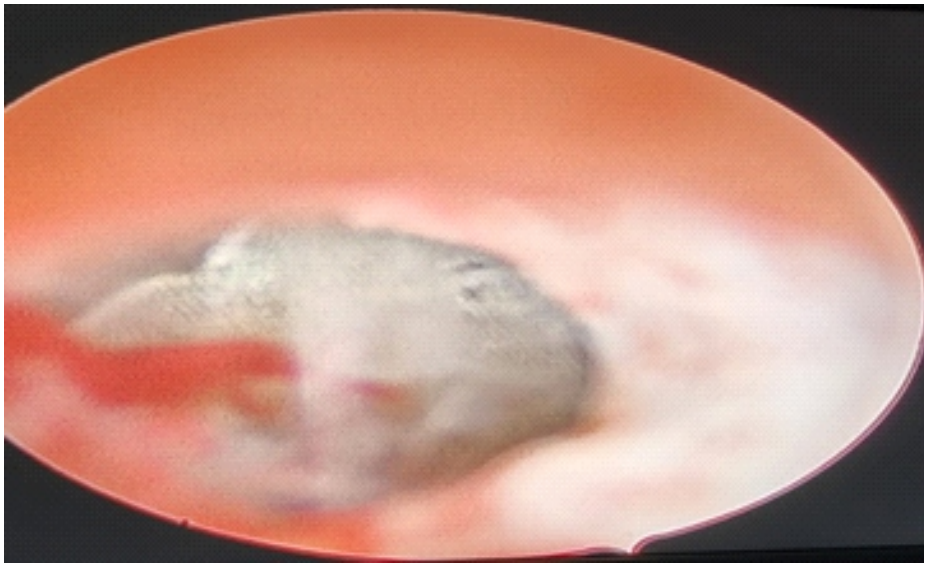

Figure 6: Diagnostic vaginoscopy showing foreign body

Figure 7: Lipstick cap measuring 3x2 cm extracted from vaginal cavity.

DISCUSSION

Vaginal foreign bodies (VFBs) in children and adolescents pose a diagnostic challenge, particularly when the presentation is atypical and genital symptoms are absent. Most published cases describe persistent vaginal discharge, foul smell, bleeding, or recurrent vulvovaginitis prompting further evaluation [16,17]. Case reports published by Dr. Kylie Fowler et al. [25] and Closson FT et al. [26] have described vaginal discharge as the primary complaint in cases of vaginal foreign body. In our case, the patient had no vaginal symptoms and denied any vaginal manipulations.

The protective effects of oestrogen on the vaginal mucosa are minimal in premenarchal or early pubertal girls, making the mucosa thin, fragile, and alkaline, factors that predispose to mucosal irritation and colonisation if a foreign body is present [18]. In many classic case series, the most common offending items are toilet tissue, small toys, hair clips, plastic caps, and other small objects [19,20].

Conventional non-invasive imaging (ultrasonography, plain radiograph) often fails to detect non-radiopaque or small objects. In a retrospective review of 20 prepubertal girls undergoing vaginoscopy for persistent discharge, only one foreign body was detected on preoperative imaging, whereas vaginoscopy revealed foreign bodies in four cases [21]. This underlines the limitations of imaging and the central role of endoscopic evaluation.

More recently, a case series from a pediatric centre in 2024 reiterated that vaginoscopy remains the gold standard for diagnosis and removal of VFBs in the pediatric population, owing to minimal risk and high diagnostic yield [22].

In the present case, the foreign body was detected on MRI, after initial ultrasonography had suggested tubo-ovarian pathology with a suspicious vaginal foreign body. The MRI finding prompted a forensic and psychiatric review, followed by diagnostic vaginoscopy under general anaesthesia, leading to the successful extraction of a 3 × 2 cm cylindrical plastic lipstick-case cover. The absence of typical genital symptoms likely contributed to delayed recognition and initial misdiagnosis. Prolonged retention of vaginal foreign bodies may lead to serious complications, including chronic inflammation, ulceration, adhesions, stenosis, fistula formation (vesicovaginal, rectovaginal), vaginolith formation, recurrent urinary tract infections, or pelvic inflammatory disease [23,24]. A neglected vaginal foreign body causing formation of a vaginolith, vesicovaginal fistula, or bladder calculus has been reported, highlighting the need for prompt removal even in asymptomatic cases [23].

Therefore, clinicians should maintain a high index of suspicion for vaginal foreign bodies in any prepubertal or early-adolescent girl, even in the absence of vaginal discharge or bleeding, especially when investigations reveal pelvic pathology or when conservative treatment fails. Early endoscopic evaluation (vaginoscopy under anaesthesia) allows safe diagnosis and removal, prevents long-term sequelae, and avoids invasive surgeries or complications.

CONCLUSION

In a young girl presenting with bilateral tubo-ovarian abscess, tuberculosis remains the most likely underlying etiology. The development of a tubo-ovarian abscess secondary to bacterial pelvic inflammatory disease in a sexually inactive patient is exceedingly rare. Therefore, in such cases, the possibility of a retained vaginal foreign body should be strongly considered. MRI serves as an indispensable diagnostic modality when vaginal examination is contraindicated. The use of hysteroscopy as an adjunct for foreign body removal is highly valuable. Given the potential medicolegal implications, including those related to the POCSO Act, involvement of the forensic team is warranted. Additionally, counselling and psychological support, with participation from the psychiatry team, are essential components of comprehensive management.

CLINICAL SIGNIFICANCE

The clinical significance of this study lies in its potential to bridge the gap between research findings and practical healthcare applications. It emphasizes the importance of translating scientific observations into meaningful improvements in patient care, diagnosis, and treatment outcomes. By highlighting real-world relevance, the study contributes to evidence based medical practice and supports informed clinical decision making. Ultimately, the findings aim to enhance patient quality of life, optimize

therapeutic strategies, and promote better disease management in clinical settings.

ABBREVIATIONS

VFBs: Vaginal Foreign Bodies
MRI: Magnetic Resonance Imaging
TOA: Tubo-Ovarian Abscess
PID: Pelvic Inflammatory Disease
UTI: Urinary Tract Infection

AUTHOR INFORMATION

Dr Pallavi Krishna: Junior Resident
Prof. Dr Pushpawati Thakur: Professor
Prof. Dr Sarita Agrawal: Professor & Head
Dr Sarita Rajbhar:Additional Professor
Dr Manish Kumar: Associate Professor
Prof. Dr Nitin Kumar Borkar: Professor & Head
Dr Nisha Watti: Assistant Professor

AUTHOR CONTRIBUTIONS

All authors significantly contributed to the study conception and design, data acquisition, or data analysis and interpretation. They participated in drafting the manuscript or critically revising it for important intellectual content, consented to its submission to the current journal, provided final approval for the version to be published, and accepted responsibility for all aspects of the work. Additionally, all authors meet the authorship criteria outlined by the International Committee of Medical Journal Editors (ICMJE) guidelines.

ACKNOWLEDGEMENT

The authors sincerely acknowledge the seniors of the Department of Obstetrics & Gynecology, All India Institute of Medical Sciences, Raipur, Chhattisgarh, India. We are grateful to our college for providing the necessary resources to carry out this work. We also extend our heartfelt thanks to our colleagues and technical staff for their valuable assistance during the study.

CONFLICT OF INTEREST

Authors declared that there is no conflict of interest.

FUNDING

None

ETHICAL APPROVAL & CONSENT TO PARTICIPATE

All necessary consent & approval was obtained by authors.

CONSENT FOR PUBLICATION

All necessary consent for publication was obtained by authors.

DATA AVAILABILITY

All data generated and analyzed are included within this research article. The datasets utilized and/or analyzed in this study can be obtained from the corresponding author upon a reasonable request.

USE OF ARTIFICIAL INTELLIGENCE (AI) & LARGE LANGUAGE MODEL (LLM)

The authors confirm that no AI & LLM tools were used in the writing or editing of the manuscript, and no images were altered or manipulated using AI & LLM.

AUTHOR'S NOTE

This article serves as an important educational tool for the scientific community, offering insights that may inspire future research diretions. However, they should not be relied upon independently when making treatment decisions or developing public health policies.

PUBLISHER'S NOTE

All statements made in this article are the sole responsibility of the authors and do not necessarily reflect the views of the publisher, editors, or reviewers. The journal maintains a neutral stance regarding jurisdictional claims in institutional affiliations presented in published work.

ARCHIVING INFORMATION

- zenodo
- Self-archiving on Google and Amazon Web Services (AWS) cloud servers, as well as on three dedicated in-house servers

MANAGING & PUBLISHING EDITOR

HANDLING EDITOR

REFERENCE

1. Stricker T, Lautenschlager S, Sennhauser FH. Vaginal foreign bodies. Arch Dis Child. 2004;89(3):333-334.
2. Emans SJ, Laufer MR, Goldstein DP. Pediatric and adolescent gynecology. 6th ed. Philadelphia: Lippincott Williams & Wilkins; 2012:1-574.
3. Casey PM, Long ME, Marnach ML. Vaginal foreign body in prepubertal girls: clinical and radiologic evaluation. Obstet Gynecol. 2009;114(3):689-692.
4. Schwarz T, Barash J, Diaz A. The assessment of suspected vaginal foreign body and child sexual abuse. J Pediatr Adolesc Gynecol. 2011;24(4):81-84.
5. Ekinci S, Karnak İ, Tanyel FC, Çiftçi AÖ. Prepubertal vaginal discharge: vaginoscopy to rule out foreign body. Turk J Pediatr. 2016;58(2):168-171.

6. Neglected vaginal foreign body leading to vaginolith, vesicovaginal fistula and vesical calculus formation in an adolescent girl. BJR Case Rep. 2015;2(2):1-3. doi:10.1259/bjrcr.20150474.
7. Wambugu J, Warfa K. Vaginal foreign bodies in pediatric population-presentation, diagnostic challenges, and role of vaginoscopy: a case series. J Obstet Gynaecol East Cent Africa. 2024;36(1):1-10. doi:10.59692/jogeca.v36i1.146.
8. Child sexual abuse unmasked due to vaginal foreign body: case review. J Pediatr Surg. 2023;19:202-206.
9. Yıldız S, Ekin M, Cengiz H, Dağdeviren H, Kaya C. Vaginal foreign body: successful management with vaginoscopy. J Turk Ger Gynecol Assoc. 2013;14(1):46-47. doi:10.5152/jtgga.2013.10.
10. Shui LT, Lee CL, Yen CF, Wang CJ, Soong YK. Vaginoscopy using hysteroscope for diagnosis of vaginal bleeding during childhood: case report. Chang Gung Med J. 1999;22(2):344-347.
11. Nayak S, Feldman-Witchel S, Sanfilippo JS. Vaginal foreign body: a delayed diagnosis. J Pediatr Adolesc Gynecol. 2014;27:127-129. doi:10.1016/j.jpag.2013.10.006.
12. Herman-Giddens ME. Vaginal foreign bodies and child sexual abuse. Arch Pediatr Adolesc Med. 1994;148(2):195-200.
13. Goodwin K, Fleming N, Dumont T. Tubo-ovarian abscess in virginal adolescents: exposure of the underlying etiology. J Pediatr Adolesc Gynecol. 2013;26(5):111-115.
14. Muram D, Drouin P, Thompson FE, Oxorn H. Pelvic inflammatory disease in virginal girls. Can Med Assoc J. 1986;134(1):27-30.
15. Granberg S, Gjelland K, Ekerhovd E. The management of pelvic abscess. Best Pract Res Clin Obstet Gynaecol. 2009;23(5):667-678. doi:10.1016/j.bpobgyn.2009.01.010.
16. Esmaeili M, Mansouri A, Ghane F. Foreign body as a cause of vaginal discharge in childhood. Acta Med Iran. 2008;46(1):75-76.
17. Seck NF, Zeng FTA, Ndoye NA, Ngom G. Intravaginal foreign body: a rare cause of persistent vaginal discharge in a child. Afr J Paediatr Surg. 2024;21(3):207-9.
18. Sharma JB, Roy KK, Pushparaj M, Kumar S, Malhotra N, Mittal S. Genital tuberculosis: an important cause of Asherman's syndrome in India. Arch Gynecol Obstet. 2008;277(1):37-41. doi:10.1007/s00404-007-0419-0.
19. Varma TR. Genital tuberculosis and subsequent fertility. Int J Gynaecol Obstet. 1991;35(1):1-11.
20. Sharma JB. Current diagnosis and management of female genital tuberculosis. J Obstet Gynaecol India. 2015;65(6):362-371.
21. Neonakis IK, Spandidos DA, Petinaki E. Female genital tuberculosis: a review. Scand J Infect Dis. 2011;43(8):564-572. doi:10.3109/00365548.2011.568523.
22. Chidambaram VC, Pallavee P. Foreign body in vagina: a cause of persistent vaginal discharge in a prepubescent child. Int J Reprod Contracept Obstet Gynecol. 2020;9(9):3883-3884. doi:10.18203/2320-1770.ijrcog20203875.
23. Gobbur VR, Gobbur RH, Patil AG, Endigeri P. A rare case of foreign body causing recurrent vaginal discharge in prepubertal child. J Clin Diagn Res. 2015;9(1):1-2. doi:10.7860/JCDR/2015/10227.5364.
24. Short A, Sit A, Gerstl B, Mallinder H, Deans R. Vaginoscopy to investigate vaginal bleeding and discharge in prepubertal girls. Aust N Z J Obstet Gynaecol. 2025;65(1):140-146. doi:10.1111/ajo.13872.
25. Umans E, Boogaerts M, Vergauwe B, Verest A, Van Calenbergh S. Vaginal foreign body in the pediatric patient: a systematic review. Eur J Obstet Gynecol Reprod Biol. 2024;297:153-158.
26. Closson FT, Lichenstein R. Vaginal foreign bodies and child sexual abuse: an important consideration. West J Emerg Med. 2013;14(5):437-439. doi:10.5811/westjem.2013.1.13347.